FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041806

Facility Name: HEARTLAND HLTH CR CTR-GALESBRG

Address: 280 East Losey Street (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 343-2166 **Fax #** (309) 343-3289

IDPA ID Number:

Date of Initial License for Current Owners: 01/01/64

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice-President Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 10/01/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	76	25,829	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	76	25,829	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	741	1,206	6,849	8,796	8
9	SNF/PED					9
10	ICF	6,486	5,221	1,289	12,996	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,227	6,427	8,138	21,792	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.37%

D. How many bed-hold days during this year were paid by Public Aid? 73 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 6,070

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	101,565	8,902	5,527	115,994	1,215	117,209		117,209			1
2	Food Purchase		98,836		98,836		98,836	(761)	98,075			2
3	Housekeeping	60,954	8,729	1,312	70,995		70,995		70,995			3
4	Laundry	25,107	5,078	3,915	34,100		34,100		34,100			4
5	Heat and Other Utilities			95,512	95,512	4,428	99,940	(2,032)	97,908			5
6	Maintenance	41,095	4,187	18,737	64,019		64,019		64,019			6
7	Other (specify):* Med Waste			561	561		561		561			7
8	**TOTAL General Services**	228,721	125,732	125,564	480,017	5,643	485,660	(2,793)	482,867			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,036,290	94,646	32,697	1,163,633	26,123	1,189,756		1,189,756			10
10a	Therapy	267,849	600	10,333	278,782		278,782		278,782			10a
11	Activities	36,517	3,047	1,159	40,723		40,723	(90)	40,633			11
12	Social Services	73,475	238	1,090	74,803		74,803		74,803			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,414,131	98,531	54,279	1,566,941	26,123	1,593,064	(90)	1,592,974			16
	C. General Administration											
17	Administrative	57,881		212,802	270,683	(77,201)	193,482		193,482			17
18	Directors Fees											18
19	Professional Services			40,646	40,646		40,646	(40,646)				19
20	Dues, Fees, Subscriptions & Promotions			50,539	50,539		50,539	(41,361)	9,178			20
21	Clerical & General Office Expenses	95,641	36,114	12,776	144,531		144,531	(4,273)	140,258			21
22	Employee Benefits & Payroll Taxes			404,711	404,711	29,467	434,178		434,178			22
23	Inservice Training & Education			3,014	3,014		3,014		3,014			23
24	Travel and Seminar			13,979	13,979		13,979		13,979			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,664	76,664		76,664		76,664			26
27	Other (specify):*			228	228		228	(404)	(176)			27
28	**TOTAL General Administration**	153,522	36,114	815,359	1,004,995	(47,734)	957,261	(86,684)	870,577			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,796,374	260,377	995,202	3,051,953	(15,968)	3,035,985	(89,567)	2,946,418			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG #0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			160,471	160,471	15,968	176,439		176,439			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,170	49,170		49,170		49,170			32
33	Real Estate Taxes			52,783	52,783		52,783	4,617	57,400			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,914	30,914		30,914		30,914			35
36	Other (specify):*											36
37	**TOTAL Ownership**			293,338	293,338	15,968	309,306	4,617	313,923			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,607	33,334	245,941		245,941		245,941			39
40	Barber and Beauty Shops			6,466	6,466		6,466		6,466			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,777	37,777		37,777		37,777			42
43	Other (specify):*		36,811		36,811		36,811		36,811			43
44	**TOTAL Special Cost Centers**		249,418	77,577	326,995		326,995		326,995			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,796,374	509,795	1,366,117	3,672,286		3,672,286	(84,950)	3,587,336			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(761)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,032)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(547)	21		13
14	Non-Care Related Interest	(5,045)	21		14
15	Non-Care Related Owner's Transactions	(90)	21		15
16	Personal Expenses (Including Transportation)	(404)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,983)	21		18
19	Entertainment	(90)	11		19
20	Contributions	(90)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(40,646)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	3,482	21		24
25	Fund Raising, Advertising and Promotional	(41,361)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	4,617	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (84,950)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,950)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HEARTLAND HLTH CR CTR-GALESBRG

ID# 0041806

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(761)	0	0	0	0	0	0	0	0	0	0	(761)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,032)	0	0	0	0	0	0	0	0	0	0	(2,032)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,793)	0	0	0	0	0	0	0	0	0	0	(2,793)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(90)	0	0	0	0	0	0	0	0	0	0	(90)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(90)	0	0	0	0	0	0	0	0	0	0	(90)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,646)	0	0	0	0	0	0	0	0	0	0	(40,646)	19
20	Fees, Subscriptions & Promotions	(41,361)	0	0	0	0	0	0	0	0	0	0	(41,361)	20
21	Clerical & General Office Expenses	(4,273)	0	0	0	0	0	0	0	0	0	0	(4,273)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(404)	0	0	0	0	0	0	0	0	0	0	(404)	27
28	**TOTAL General Administration**	(86,684)	0	0	0	0	0	0	0	0	0	0	(86,684)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(89,567)	0	0	0	0	0	0	0	0	0	0	(89,567)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	4,617	0	0	0	0	0	0	0	0	0	0	4,617	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,617	0	0	0	0	0	0	0	0	0	0	4,617	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(84,950)	0	0	0	0	0	0	0	0	0	0	(84,950)	45

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation	Toledo,OH			
Manor Care, Inc.		of America				
		(See H.O Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See	Home Office Allocation	$ 212,802	HCR Manor Care,Inc.	100.00%	$ 212,802	$	1
2	V		Page							2
3	V		8							3
4	V									4
5	V									5
6	V		10a	Therapy Management	8,756	Heartland Management Services	100.00%	8,756		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 221,558			$ 221,558	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBR(# 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	$	$	3,697,254	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	940,169	509,589	3,697,254	1,215	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	288,728		3,697,254	444	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	3,082,391		3,697,254	3,984	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	11,758,547	7,451,541	3,697,254	18,092	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	6,213,378	3,630,890	3,697,254	8,031	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	17,137,345	15,146,077	3,697,254	26,368	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	84,513,196	36,356,102	3,697,254	109,233	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	4,283,731		3,697,254	6,591	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	17,698,741		3,697,254	22,876	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.			3,697,254	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	12,354,014		3,697,254	15,968	12
13										13
14	32	Interest				11,412,188				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,682,428	$ 63,094,199		$ 212,802	25

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America *		X	Finance Capital Additions	N/A		$ 964,387	$			$ 6,211	1
2	*Note was paid off in current year											2
3	National City Bank, Trustee		X	Finance Capital Additions	N/A			964,387			42,959	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 964,387	$ 964,387			$ 49,170	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 964,387	$ 964,387			$ 49,170	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	48,166	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	52,783	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,617	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	52,783	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	57,400	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	43,552	8
1999	42,064	9
2000	45,579	10
2001	48,166	11
2002	52,783	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HEARTLAND HLTH CR CTR-GALESBRG COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0041806

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	9910427016	See Attached	$ 52,783	$ 52,783
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,783.00	$ 52,783.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Masonary Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983	$ 54,305	1
2	Facility		2003	67,630	2
3	TOTALS			$ 121,935	3

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1964	1964	$ 407,801	$ 1,188	30	$ 1,188	$	$ 408,989	4
5	7			2003	570,110						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					93,910		93,910		754,215	9
10	Building Improvements			1968	73						10
11	Building Improvements			1969	1,059						11
12	Building Improvements			1970	1,083						12
13	Building Improvements			1971	10,602						13
14	Building Improvements			1972	5,946						14
15	Building Improvements			1973	758						15
16	Building Improvements			1974	817						16
17	Building Improvements			1975	3,645						17
18	Building Improvements			1978	19,333						18
19	Land Improvements			1983	1,350						19
20	Building Improvements			1984	21,913						20
21	Building Improvements			1985	42,479						21
22	Land Improvements			1985	8,457						22
23	Building Improvements			1986	23,347						23
24	Land Improvements			1986	2,349						24
25	Building Improvements			1987	19,172						25
26	Building Improvements			1988	14,265						26
27	Land Improvements			1988	1,470						27
28	Building Improvements			1989	36,615						28
29	Land Improvements			1990	1,500						29
30	Building Improvements			1990	27,793						30
31	Building Improvements			1991	9,501						31
32	Building Improvements			1992	24,536						32
33	Building Improvements			1993	16,600						33
34	Land Improvements			1994	3,095						34
35	Building Improvements			1994	1,278						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Land Improvements	1995	$ 1,098	$		$	$	$	37
38	Building Improvements	1995	14,214						38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693						39
40	engineering fees, demolition, masonary, concrete, drywall,								40
41	windows, doors, wood trim, paint, counter tops, electrical								41
42	Building Improvements : Wallcovering	1996	79,684						42
43	Building Improvements : Carpet and vinyl	1996	33,131						43
44	Builiding Improvements : Ceramic flooring	1996	40,886						44
45	Building Improvements : Millwork	1996	25,990						45
46	Building Improvements : Electrical lighting, plumbing fixtures, hand	1996	51,580						46
47	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,								47
48	vinyl flooring								48
49	Building Improvements : Doors	1997	10,728						49
50	Building Improvements : Electrical composite, automatic doors,	1997	38,947						50
51	metal doors, fire alarm system								51
52	Building Improvements : Capalo	1997	2,500						52
53	Building Improvements : Generator	1997	7,743						53
54	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556						54
55	Building Improvements : Onan Genator	1997	17,482						55
56	Building Improvements : Soffits, gutters & trim	1997	9,962						56
57	Building Improvements : Generator	1997	24,885						57
58	Land Improvements - Sidewald	1998	7,988						58
59	Building Improvements - Fire Prevention System	1998	35,013						59
60	Building Improvements - HVAC	1997	42,499						60
61	Sidewalk	1999	7,988						61
62	Sidewalk	1999	900						62
63	Overhead from const	1999	2,681						63
64	Power control wiring for ne	1999	2,392						64
65	Sprinkler system upgrade	1999	19,107						65
66	Air compressor	1999	598						66
67	Laundry room floor	1999	1,800						67
68	Sprinkler upgrade	1999	23,940						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,270,932	$ 95,098		$ 95,098	$	$ 1,163,204	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,270,932	$ 95,098		$ 95,098	$	$ 1,163,204	1
2	Fire sprinkler system	1999	2,971						2
3	Boiler	1999	33,600						3
4	HVAC upgrade	1999	2,420						4
5	Building improvements	1999	1,200						5
6	SMOKING HUT	2000	4,950						6
7	CONCRETE FOR SMOKE HUT	2000	350						7
8	CABINETRY	2000	3,690						8
9	ELECTRICAL	2000	20,205						9
10	ADDT'L COST SMOKING HUT	2000	645						10
11	ELECTRICAL	2000	10,880						11
12	ELECTRICAL	2000	3,454						12
13	HVAC	2000	21,662						13
14	ELECTRICAL/NEW OFFICE	2000	860						14
15	CABINETS	2000	1,369						15
16	HVAC	2000	1,736						16
17	HVAC	2000	193						17
18	ADDT'L COST FOR SPRINKLER SYST	2000	15,146						18
19	AIR / HUMIDIFIER COIL	2001	5,233						19
20	CANOPY	2001	1,200						20
21	CONCRETE PATIO	2001	5,500						21
22	VWC	2002	1,172						22
23	Carpet	2002	1,534						23
24	Roof Upgrade - AUDIT ADJ 7/1/03 (#5) - CHG YEAR	2001	98,494						24
25	Border	2002	111						25
26	Border	2002	125						26
27	Brick Work	2002	5,787						27
28	Addition Cost Brick Work	2002	643						28
29	Artwork	2002	2,219						29
30	Paint & Wallcovering	2002	2,810						30
31	Paint & Wallcovering	2002	3,122						31
32	Overhead & Interest	2003	431						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,642	$ 95,098		$ 95,098	$	$ 1,163,204	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,524,642	$ 95,098		$ 95,098	$	$ 1,163,204	1
2	Carpet & Painting - AUDIT ADJ 7/1/03 (#9) - CHG YEAR	2002	34,932						2
3	Paint, Flooring & VWC	2003	12,182						3
4	Paint, Flooring & VWC	2003	1,354						4
5	Freight on Carpet	2003	56						5
6	Carpet, Wallcovering and Corner Guards	2003	12,197						6
7	Developers Costs - Architect & Engineering Fees	2003	96,312						7
8	Developers Costs - T&E, Reprod.,Permit & Plan Review Fees	2003	15,798						8
9	Developers Costs - Overhead	2003	152,775						9
10	Developers Costs - Interest	2003	13,748						10
11	Millwork	2003	4,664						11
12	Soil and Concrete Testing, Water & Sewer Fees	2003	6,851						12
13	Site Work/Preparation	2003	74,492						13
14	AUDIT ADJ 7/1/03 (#1) - PG 12A, LINE 45	2003	(627)	(42)		(42)		(315)	14
15	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 62	2003	(900)	(90)		(90)		(435)	15
16	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 63	2003	(2,681)	(134)		(134)		(659)	16
17	AUDIT ADJ 7/1/03 (#3) - PG 12A, LINE 65	2003	(1,740)	(87)		(87)		(397)	17
18	AUDIT ADJ 7/1/03 (#4) - PG 12B, LINE 18	2003	(15,146)	(757)		(757)		(2,461)	18
19	AUDIT ADJ 7/1/03 (#6) - PG 12B, LINE 24	2003	(6,839)	(684)		(684)		(1,254)	19
20	AUDIT ADJ 7/1/03 (#7) - PG 12B, LINE 29	2003	(2,219)	(592)		(592)		(592)	20
21	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 32	2003	(431)	(40)		(40)		(40)	21
22		2003							22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,919,420	$ 92,672		$ 92,672	$	$ 1,157,051	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 897,901	$ 67,799	$ 67,799	$		$ 696,130	71
72	Current Year Purchases	208,606						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			15,968	15,968			74
75	TOTALS	$ 1,106,507	$ 67,799	$ 83,767	$ 15,968		$ 696,130	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van With		$ 20,718	$	$	$		$ 20,718	76
77		Chair Lift								77
78										78
79										79
80	TOTALS			$ 20,718	$	$	$		$ 20,718	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,168,580	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,471	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 176,439	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,968	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,873,899	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 30,914 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	5791 hrs	$ 144,765	193	$ 4,831	$ 421	5,984	$ 150,017	1
2	Licensed Speech and Language Development Therapist	10A	1904 hrs	47,611	56	1,397	84	1,960	49,092	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	3019 hrs	75,473	169	4,233	95	3,188	79,801	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				212,601		212,601	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S X-Ray,Lab	10a,39,Col.3				33,206	6		33,212	13
14	TOTAL			$ 267,849	418	$ 43,667	$ 213,207	11,132	$ 524,723	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG **#** 0041806 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (33,161)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (102,983))	652,796		3
4	Supply Inventory (priced at)	18,395		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 638,030	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	121,935		13
14	Buildings, at Historical Cost	2,919,420		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,127,225		16
17	Accumulated Depreciation (book methods)	(1,873,899)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	427		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,295,108	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,933,138	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 18,266	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,830		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,783		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	60,974		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 284,853	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	964,387		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 964,387	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,249,240	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,683,898	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,933,138	$	48

***(See instructions.)**

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 804,447	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 804,447	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	302,096	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 302,096	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	577,355	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 577,355	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,683,898	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,187,871	1
2	Discounts and Allowances for all Levels	(868,485)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,319,386	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,348,610	6
7	Oxygen	14,115	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,362,725	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	664	12
13	Barber and Beauty Care	7,640	13
14	Non-Patient Meals	761	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	225,069	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,895	19
20	Radiology and X-Ray	11,425	20
21	Other Medical Services	867	21
22	Laundry	2,815	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 287,136	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,045	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,045	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	90	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 90	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,974,382	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	480,017	31
32	Health Care	1,566,941	32
33	General Administration	1,004,995	33
	B. Capital Expense		
34	Ownership	293,338	34
	C. Ancillary Expense		
35	Special Cost Centers	326,995	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,672,286	40
41	**Income before Income Taxes (line 30 minus line 40)****	302,096	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 302,096	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,019	2,183	$ 53,078	$ 24.31	1
2	Assistant Director of Nursing	1,917	2,073	41,601	20.07	2
3	Registered Nurses	10,788	11,667	230,275	19.74	3
4	Licensed Practical Nurses	15,393	16,647	248,274	14.91	4
5	Nurse Aides & Orderlies	46,301	50,070	448,998	8.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	10,005	10,783	267,311	24.79	7
8	Rehab/Therapy Aides	45	49	538	10.98	8
9	Activity Director	3,334	3,612	36,517	10.11	9
10	Activity Assistants					10
11	Social Service Workers	4,929	5,333	73,475	13.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,668	13,699	101,565	7.41	15
16	Dishwashers					16
17	Maintenance Workers	2,288	2,479	41,095	16.58	17
18	Housekeepers	7,998	8,661	60,954	7.04	18
19	Laundry	3,113	3,365	25,107	7.46	19
20	Administrator	2,276	2,080	57,881	27.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,816	8,773	95,641	10.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,625	1,760	14,064	7.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,515	143,234	$ 1,796,374 *	$ 12.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	9,000	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7	$ 140	5,10,3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	7	$ 140		53

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	Administrator	0	$ 57,881
Cindy Zolper			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,881

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 212,802
TOTAL (agree to Schedule V, line 17, col. 3)	$ 212,802
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Husch&Eppenberger,	Legal Fees	$ 40,646
Smith Reed,LLP and		
VanOstrand&Elvidge Kelley		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,646

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,516
Unemployment Compensation Insurance	19,226
FICA Taxes	124,269
Employee Health Insurance	173,252
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K / SMSP Match	1,313
Other Employee Benefits	4,805
Employee Uniforms	2,471
Employee Vaccinations	1,859
Home Office Allocation	29,467
TOTAL (agree to Schedule V, line 22, col.8)	$ 434,178

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,015
Advertising: Employee Recruitment	4,421
Health Care Worker Background Check	
(Indicate # of checks performed 55)	1,107
Dues & Subscriptions	445
Association Dues	3,134
Advertising	40,417
Less: Non-Allowable Assoc. Dues	(944)
Less: Public Relations Expense	( )
Non-allowable advertising	(40,417)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,178

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	13,979
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,979

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HEARTLAND HLTH CR CTR-GALESBRG **#** 0041806 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,134**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,556** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **37,777**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **761**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.